114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
MEDICAL SECURITY BUREAU

114.6 CMR 13.00: HEALTH SAFETY NET ELIGIBLE SERVICES

13.01 General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 13.00 governs the criteria effective October 1, 2008 for determining the services for which hospitals and community health centers may be paid from the Health Safety Net Office, including the types of services that will be paid by the Office and the criteria to determine Low Income Patient status; to determine medical hardship; and to submit claims for bad debt. Payment rates for Eligible Services are set forth in 114.6 CMR 14.00.

(2) Authority: 114.6 CMR 13.00 is adopted pursuant to M.G.L. c. 118G.

13.02 Definitions

Meaning of Terms: As used in 114.6 CMR 13.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 13.00 are capitalized.

340B Pharmacy. A Hospital or Community Health Center eligible to purchase discounted drugs through a program established by Section 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients, and is registered and listed as a 340B Pharmacy within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. 340B Pharmacy services may be provided at on-site or off-site locations.

Ancillary Services. Non-routine services for which charges are customarily made in addition to routine charges, that include, but are not limited to, laboratory, diagnostic and therapeutic radiology, surgical services, and physical, occupational or speech-language therapy. Generally ancillary services are billed as separate items when the patient receives these services.

Bad Debt. An account receivable based on services furnished to a patient which: (i) is regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 114.6 CMR 13.06; (ii) is charged as a credit loss; (iii) is not the obligation of a governmental unit or the federal government or any agency thereof; and (iv) is not a Reimbursable Health Care Service.

Caretaker Relative. An adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Charge. The uniform price for a specific service charged by a Provider.

Children's Medical Security Plan (CMSP). A program of primary and preventive pediatric health care services for eligible children, from birth to age 18, administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E, § 10F.

Collection Action. Any activity by which a Provider or designated agent requests payment for services from a patient, a patient's guarantor, or a third party responsible for payment. Collection Actions include activities such as pre-admission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

CommonHealth. A MassHealth program for disabled adults and disabled children administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E.

Commonwealth Care. An insurance program for low-income individuals administered by the Commonwealth Health Insurance Connector pursuant to M.G.L. c. 118H.

Community Health Center. A health center operating in conformance with the requirements of Section 330 of United States Public Law 95-926, including all community health centers which file cost reports as requested by the Division of Health Care Finance and Policy (Division). Such health center must (a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51; (b) meet the qualifications for certification (or provisional certification) by the Office of Medicaid and enter into a provider agreement pursuant to 130 CMR 405.000; and (c) operate in conformance with the requirements of 42 U.S.C. § 254(c).

Confidential Services. Services for the treatment of sexually transmitted diseases provided under M.G.L. c. 112, § 12F and family planning services provided under M.G.L. c. 111, § 24E.

Critical Access Services. Those health services which are generally provided only by acute hospitals, as further defined in 114.6 CMR 13.03.

Emergency Aid to the Elderly, Disabled and Children (EAEDC). A program of governmental benefits under M.G.L. c. 117A.

Emergency Medical Condition. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services. Medically necessary services provided to an individual with an Emergency Medical Condition.

EMTALA. The federal Emergency Medical Treatment and Active Labor Act under 42 U.S.C. § 1395(dd).

Family. Persons who live together, and consisting of: (1) a child or children under age 19, any of their children, and their parents; (2) siblings under age 19 and any of their children who live together even if no adult parent or Caretaker Relative is living in the home; or (3) a child or children under age 19, any of their children, and their Caretaker Relative when no parent is living in the home. A Caretaker Relative may choose whether or not to be part of the Family. A parent may choose whether or not to be included as part of the Family of a child under age 19 only if that child is: a) pregnant; or b) a parent. A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children that live with them.

Family Income. Gross earned and unearned income as defined in 130 CMR 506.003.

Federal Poverty Limit (FPL). Income standards issued annually in the Federal Register.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the following calendar year.

Fund. The Health Safety Net Trust Fund, established by M.G.L. c. 118G, § 36.

Governmental Unit. The Commonwealth, any department, agency board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Income. The total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Guarantor. A person or group of persons that assumes the responsibility of payment for all or part of a Provider's charge for services.

Health Insurance Plan. The Medicare program, the MassHealth program, Commonwealth Care, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.

Health Practitioner. An individual who can diagnose and treat medical problems whether by authority of his or her own license or by the delegated authority of a licensed medical professional.

Health Services. Medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs association with the provision of blood and its derivatives shall be payable.

Healthy Start. A health care program for pregnant women and infants administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E, § 10E.

Hospital Visit. A face-to-face meeting between a patient and a physician, physician assistant, nurse practitioner, or registered nurse when the patient has been admitted to a hospital by a physician on a Community Health Center's staff.

Hospital. An acute Hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Hospital Licensed Health Center. A facility that is not physically attached to the Hospital, or located on or proximate to the Hospital campus, that: (1) operates under the Hospital 's license; (2) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center under 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth Enrollment Unit as a Hospital Licensed Health Center; (4) is subject to the fiscal, administrative and clinical management of the Hospital; and (5) provides services solely on an outpatient basis.

Hospital Services. Services listed on an acute Hospital license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

Individual Medical Visit. A face-to-face meeting at a Community Health Center between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, or registered nurse for medical examination, diagnosis or treatment.

Low Income Patient. An individual who meets the criteria under 114.6 CMR 13.04(1).

MassHealth. The medical assistance program administered by the Executive Office of Health and Human Services Office of Medicaid pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a Section 1115 Demonstration Waiver.

MassHealth Application. A form prescribed by the Office of Medicaid to be completed by the Applicant or an Eligibility Representative, and submitted to the Office of Medicaid as a request for MassHealth benefits. It is either the Medical Benefits Request (MBR) or the common intake form designated by the Executive Office of Health and Human Services, or any other form designated by the Office of Medicaid.

Medically Necessary Service. A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Mental Health Services. A comprehensive group of diagnostic and psychotherapeutic treatment services to mentally or emotionally disturbed persons and their families by an interdisciplinary team under the medical direction of a psychiatrist.

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B Pharmacies.

Patient. An individual who receives or has received medically necessary services at a Hospital or Community Health Center.

Pharmacy Online Processing System (POPS). The MassHealth online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and patient eligibility verification.

Primary or Elective Care. Medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. Primary care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants. Primary Care does not require the specialized resources of a Hospital emergency department and excludes Ancillary Services and maternity care services.

Provider. A Hospital or Community Health Center that provides Eligible Services.

Reimbursable Health Services. Eligible Services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or in part; provided that the health services are emergency, urgent and critical access services provided by Hospitals or services provided by Community Health Centers; and provided further, that such services shall not be eligible for reimbursement by any other public or third party payer.

Reimbursable Services. Eligible Services for which a Provider may submit a claim to the Health Safety Net Trust Fund as defined in 114.6 CMR 13.00.

Resident. A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

REVS System. The MassHealth Recipient Eligibility Verification System of the Office of Medicaid.

Underinsured Patient. A patient whose Health Insurance Plan or self-insurance plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net Trust Fund, provided that the patient meets income eligibility standards set forth in 114.6 CMR 13.03.

Uninsured Patient. A patient who is a resident of the Commonwealth, who is not covered by a health insurance plan or a self-insurance plan and who is not eligible for a medical assistance program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care. Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

13.03 Eligible Service Requirements

(1) General. To qualify as a Service Eligible for Payment, the service must meet the following criteria:

(a) Eligible Service Categories. There are three categories of services eligible for payment from the Health Safety Net Office:

1. Health Safety Net - Primary, Health Safety Net - Secondary, Health Safety Net - Partial Services to Low Income Patients in accordance with 114.6 CMR 13.04;
2. Medical Hardship Services in accordance with 114.6 CMR 13.05; and
3. Bad Debt in accordance with 114.5 CMR 13.06.

(b) Eligible Service Limitations - General. The Health Safety Net Office will not pay for, and Providers may not submit claims to the Office for, services that are not medically necessary or for which another public or private payer is responsible. The Health Safety Net Office is the payer of last resort.

1. The Health Safety Net Office may request, and the Provider must provide, any and all medical records (or clear photocopies of such records) corresponding to or documenting the services claimed upon request of the Health Safety Net Office or its agent.
2. The medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care provided to a patient for each service claimed for payment.
3. For Services for which MassHealth requires prior approval, the Provider must ensure that current clinical standards are used to determine whether the service is medically necessary. The Health Safety Net Office may audit claims to verify medical necessity.

(c) Eligible Service Limitations - Low Income Patients.

1. For insured Low Income Patients, the Health Safety Net Office will not pay for, and Providers may not submit claims for, services for which the primary insurer has denied payment because of a technical billing error; because the patient obtained out of network services; or because the patient failed to obtain required prior authorization for services. The Health Safety Net Office will not pay claims for the balance of an insurer's contractual allowance or for late charges for a service that has been paid by another payer.

2. For insured Low Income Patients with private insurance, including Student Health Plans and Young Adult Plans, the Health Safety Net Office will pay only for deductibles, coinsurance, and Reimbursable Services not covered by the insurer. The Health Safety Net Office will not pay for co- payments required by a private insurer.

3. For Low Income Patients who are MassHealth members enrolled in MassHealth Limited, EAEDC, Prenatal, Healthy Start, Healthy Start plus Limited, CMSP, CMSP plus Limited, and Family Assistance/Premium Assistance, the Health Safety Net Office will pay only for Reimbursable Services not covered by the member's MassHealth aid category. A Provider may submit a claim for Reimbursable Services not covered by EAEDC only if the individual's EAEDC eligibility appears in REVS. A Provider may submit a claim for Reimbursable Services not covered by CMSP only if the individual enrolled is in an aid category for those with income up to 400% of the FPL.

4. For Low Income Patients who are MassHealth members, the Health Safety Net Office will not pay for, and Providers may not submit claims to the Office for:

a. Any services provided to MassHealth members enrolled in MassHealth Standard, CommonHealth, MassHealth Essential, MassHealth Basic, or Family Assistance/Direct Coverage;

b. MassHealth co-payments; and

c. CommonHealth deductibles.

5. For Low Income Patients enrolled in Medicare, including MassHealth members enrolled in Medicare Buy-In and Senior Buy-In, the Health Safety Net Office will pay for Reimbursable Services not covered by Medicare, and Medicare co-pays, coinsurance and deductibles.

6. Low Income Patients enrolled in Commonwealth Care are eligible only for Dental Services not otherwise covered by Commonwealth Care. The Health Safety Net Office will not pay for Commonwealth Care co-pays.

7. The Health Safety Net Office will pay for, and Providers may submit claims to the Office for Reimbursable Services provided to Low Income Patients for services provided during the Eligibility Period specified in 13.04(5).

(2) Reimbursable Services.

(a) General. The Health Safety Net Office will pay only for the Reimbursable Services listed below. Providers may submit claims only for Reimbursable Services provided in accordance with the MassHealth Standard program provided by acute Hospitals and Community Health Centers using the payment codes as listed in Subchapter 6 of the MassHealth Inpatient and Outpatient Provider Manuals and other MassHealth provider manuals per the Health Safety Net provider manual. The Health Safety Net Office may add additional codes and Reimbursable Services by Administrative Bulletin.

(b) Pharmacy. The Health Safety Net Office will pay only for prescribed drugs according to the coverage rules, including 130 CMR sections 406.411: Prescription Requirements; 406.412(A) and (B)(1) Covered Drugs and Medical

Supplies; 406.413: Limitations on the Coverage of Drugs; and 406.422: Prior Authorization, established by MassHealth and processed through POPS. Providers may not submit claims for drugs listed on the MassHealth excluded drug list.

(c) 340B Pharmacies. A Provider eligible to provide 340B Pharmacy services may submit a Health Safety Net claim only for outpatient pharmacy services provided through the Provider's 340B Pharmacy unless the claim meets the following conditions: (1) the claim is submitted by a Community Health Center that directly operates both a 340B Pharmacy and a retail pharmacy and (2) the claim is for a drug provided to an individual who cannot be seen by a Provider-based prescriber to obtain a prescription within a clinically appropriate time period. The Community Health Center must inform the patient that it may not fill future prescriptions unless the individual becomes a patient of the Community Health Center. A Provider may submit a Health Safety Net claim only for the dispensing fee for covered prescribed drugs provided to Low Income Patients if that individual is using a pharmaceutical company sponsored free drug program and the drug is dispensed by the pharmacy. A Provider may not submit a Health Safety Net claim for free or donated prescribed drugs where the drugs are stored and dispensed from a site other than the pharmacy (e.g., secured closet near exam room). A Provider is eligible for Health Safety Net payments for drugs provided through its 340B Pharmacy only if it provides prescribed drugs to MassHealth members under 114.3 CMR 31.07.

(d) Utilization Review. The Health Safety Net Office will conduct a utilization review program designed to monitor the appropriateness of services for which payments are made and to promote the delivery of care in the most appropriate setting.

(e) Non-covered Services. The Health Safety Net Office does not pay for any of the following services: non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre-and post-sex-reassignment surgery hormone therapy; the provision of whole blood except for the administrative and processing costs associated with the provision of blood and its derivatives; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); vocational rehabilitation services; sheltered workshops; recreational services; life-enrichment services; alcohol or drug drop-in centers; drugs used for the treatment of obesity; cough and cold preparations; hormone therapy related to sex-reassignment surgery; drugs related to the treatment of male or female infertility; absorptive lenses of greater than 25 percent absorption; photochromatic lenses, sunglasses, or fashion tints; treatment of congenital dyslexia; extended-wear contact lenses; invisible bi-focals; and the Welsh 4-Drop Lens.

(f) No Hospital may submit a claim to the Health Safety Net Office for services related to preventable hospital-acquired infections as defined by CMS, or for serious reportable events as defined by the National Quality Forum.

(3) Reimbursable Services - Hospitals.

(a) The Health Safety Net Office will pay Hospitals only for the Hospital Services listed below, subject to the limitations in 114.6 CMR 13.03 (3) (b).

1. Abortion Services. The Health Safety Net Office will pay for first and second trimester abortions performed by a licensed physician only when the abortion is performed in accordance with M.G.L. c. 112, §§ 12K through 12U and the abortion is medically necessary, according to the medical judgment of a licensed physician in light of all factors affecting the woman's health.
2. Ambulatory Surgery Services
3. Audiologist Services
4. Chiropractic Services
5. Dental Services. The Health Safety Net Office will pay only for dental services identified in Subchapter 6 of the MassHealth *Dental Manual*.
6. Durable Medical Equipment. The Health Safety Net Office will pay only for crutches and canes provided during a medical visit.
7. Family Planning Services
8. Hearing Instrument Services
9. Inpatient Hospice Services
10. Inpatient Services
11. Inpatient Psychiatric. The Health Safety Net Office will pay only for services provided in a Medicare certified psychiatric unit.
12. Laboratory Services. The Health Safety Net Office does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis. Specimen collection and preparation is considered part of the laboratory service.
13. Medical Supplies. The Health Safety Net Office will pay for medical supplies used in the delivery of inpatient and outpatient care. It will also pay for spacers used with metered dose inhalers; nebulizers, diabetic supplies, home glucose monitors, and portable peak flow monitors.
14. Mental Health Services. The Health Safety Net Office will pay for mental health services except for non-covered services in 114.6 CMR 13.03(2)(d). The Health Safety Net Office will pay only for mental health services that meet the requirements in the MassHealth *Acute Outpatient Hospital Manual* at 410.471 through 410.475, and 410.479(A).
15. Nurse Midwife Services
16. Nurse Practitioner Services
17. Observation Services. Outpatient hospital services provided anywhere in a Hospital, to evaluate a patient's medical condition and determine the need for an inpatient admission. Observation services are provided under order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.
18. Orthotic Services
19. Outpatient Services. Outpatient Services are services provided by Hospital outpatient departments and by Hospital Licensed Health Centers. Such services include, but are not limited to, Emergency

Services, Primary Care Services, observation services, Ancillary Services, and day-surgery services.
20. Outpatient Psychiatric Services
21. Pharmacy Services
22. Physician Services. The Health Safety Net Office will pay only for services provided by Hospital-based salaried physicians.
23. Podiatrist Services
24. Prosthetic Services
25. Radiology Services
26. Rehabilitation Services. For inpatient rehabilitation, the Health Safety Net Office will pay only for services provided in a Medicare certified rehabilitation unit.
27. Renal Dialysis Services
28. Speech and Hearing Services
29. Sterilization Services
30. Substance Abuse Services, including methadone treatment as described in 130 CMR 418.000, except for non covered services in 114.6 CMR 13.03(2)(d).
31. Therapy Services. The Health Safety Net Office will pay only for therapy services as defined in the MassHealth *Acute Outpatient Hospital Manual*, sections 410.451(A) and (B). Before therapy is initiated, there must be a comprehensive evaluation of the patient's medical condition, disability and level of functioning to determine the need for treatment and, when treatment is indicated, to develop a treatment plan.
32. Tobacco Cessation. The Health Safety Net Office will pay only for services as defined by Subchapter 6 of the MassHealth *Acute Hospital Outpatient Manual*.
33. Vision Care Services. The Health Safety Net Office will pay only for services as defined by the MassHealth *Acute Hospital Outpatient Manual* at sections 410.485 through 410.488.

(b) Critical Access Service Limitation. A Hospital may submit claims only for Critical Access Services. Critical access services are medically necessary Hospital Services, including inpatient services, certain outpatient services, and services provided in a Hospital-licensed facility located off the Hospital campus that is a Hospital Licensed Health Center, a school-based health center, or other satellite location. Critical access services do not include on-campus outpatient clinic visits for non-emergent or non-urgent Primary Care unless:

1. There is no Community or Hospital Licensed Health Center providing both adult and pediatric Primary Care within 5 miles driving distance of the Hospital campus as determined by the Health Safety Net Office; or
2. The patient's medical condition is so severe or complex that his/her primary care cannot be adequately provided in a community setting. This determination shall be made by the treating clinician, and must be a reasonable clinical judgment based on prevailing standards of care. The reasons for such a determination must be documented in the patient's record.
3. Each claim submitted by a Hospital must identify the specific location at which the service was provided.

(4) Reimbursable Health Services - Community Health Centers

(a) General. Community Health Centers may submit claims only for Reimbursable Services set forth in 114.6 CMR 13.04(4)(b). The Services must meet the requirements set forth in 114.6 CMR 13.04(4)(c).

1. Community Health Centers may submit claims only for services provided under the Center's clinic license.
2. A Community Health Center may submit claims only for Services provided on site, except for off site 340B Pharmacy Services and certain Evaluation and Management visits provided to that Center's patients at an acute hospital. A Community Health Center may submit claims for dentures provided on site but manufactured or repaired at an off-site contractor.
3. The Health Safety Net Office will not pay Community Health Centers for performing, administering, or dispensing experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre-and post-sex-reassignment surgery hormone therapy, and treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment).

(b) Reimbursable Services.

1. Audiology Services. The Health Safety Net Office will pay for audiology services if the services were provided at the written request of a physician, nurse practitioner, or physician assistant who has found some indication of a hearing problem. Documentation of the request and of the hearing problem must be kept in the patient's medical record.
The Health Safety Net Office will not pay for a Medical Visit if the patient is being seen for audiology services only.
2. Behavioral Health Services
3. Cardiovascular and Pulmonary Diagnostic Services
4. Dental Services. The Health Safety Net Office will pay only for Dental Services identified in Subchapter 6 of the MassHealth *Dental Manual*.
5. Diabetes Self Management Training. The Health Safety Net Office will pay for Diabetes Self Management Training services as defined by MassHealth. The Office will not pay for a Medical Visit if the patient is being seen for Diabetes Self Management Services only.
6. Electrocardiogram (EKG) Services. The Health Safety Net Office will pay for EKG services only when the service is provided at the written request of a Community Health Center staff physician who will interpret or review the interpretation of the EKG. Documentation of the physician's request must be kept in the patient's medical record. A Community Health Center may claim payment for EKG services only when both of the following conditions are met: (1) the Center owns or rents its own EKG equipment; and (2) the EKG is taken at the Center.

The Office will not pay for a Medical Visit when the patient is being seen for an EKG only.

7. Family Planning Services. The Health Safety Net Office will pay for a medical visit for the purpose of family planning (family planning counseling services are considered part of the medical visit), prescribed drugs, family planning supplies and laboratory tests. The Office will not pay for a medical visit for the sole purpose of replenishing a patient's supply of contraceptives. In that case, the Office will pay only for the cost of the contraceptive supplies.

8. Individual Medical Visits. A face-to-face meeting at the Center between a patient and a physician, physician assistant, registered nurse or other eligible provider for medical examination, diagnosis, or treatment.

9. Laboratory Services. The Health Safety Net Office will pay only for laboratory services for which a written request for that service from an authorized subscriber is present in the patient's medical record. The Office will not pay for the following laboratory services: routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures, urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue); laboratory tests associated with male or female infertility; or such calculations as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The Office will not pay a Community Health Center for a laboratory service when the Center bills separately for the professional component of that services. The Office will not pay a Center for a Medical Visit when the patient is being seen for laboratory services only.

10. Medical Nutrition Therapy. The Health Safety Net Office will pay for Medical Nutrition Therapy services as defined by MassHealth. Medical Nutrition Therapy does not include enteral therapy. The Office will not pay for a Medical Visit if the patient is being seen for Medical Nutrition Therapy services only.

11. Obstetrical Services

12. Pharmacy Services

13. Podiatry Services

14. Radiology Services. The Health Safety Net Office will pay for radiology services only when the services are provided at the written request of a licensed physician or dentist. The professional component of a radiology service is the component for interpreting a diagnostic test of image. The technical component of a radiology service is the component for the cost of rent, equipment, utilities, supplies, administrative and technical supplies and benefits, and other overhead expenses. The Health Safety Net Office will not pay for a medical visit if the patient is being seen for radiology services only.

15. Surgery Services

16. Tobacco Cessation Services. The Health Safety Net Office will pay for Tobacco Cessation Services as defined by MassHealth. The Office will not pay for a Medical Visit if the patient is being seen for Tobacco Cessation Services only.

17. Vision Care Services

(c) Reimbursable Services Requirements. Community Health Center services must be provided in accordance with the specifications listed below. The Health Safety Net Office will pay only for services provided by the licensed professionals listed below and will pay in accordance with the codes identified below.

Service	*Provider*	*Codes*
Medical Visit	MD, NP, Podiatrist, Nurse Midwife, Physician's Assistant, RN, Doctor of Osteopathy (DO), Podiatrist	CPT Evaluation and Management codes for on-site services and certain hospital visits
Medical Visit - Urgent Care	Same as above	Code 9905
Surgical Procedure (provided on a day separate from a Medical Visit)	MD and providers listed above within licensed scope of services	CPT codes clinically appropriate for office setting

Service	*Provider*	*Codes*
Cardio and Pulmonary Diagnostic (provided on a day separate from a Medical Visit)	MD	Cardiovascular (93000 series) and Pulmonary (94000 series)
Obstetrical Services	MD, Nurse Midwife	Global OB codes
Behavioral Health (diagnostic)	MD, Licensed Psychologist, eligible Mass. licensed clinicians and eligible Masters level clinicians	CPT Behavioral Health Diagnostic codes
Behavioral Health (treatment)	MD, Licensed Psychologist, eligible Mass. licensed clinicians and eligible Masters level clinicians	CPT Behavioral Health Treatment codes
Radiology	Qualified Technician. The professional component (PC) for MD, Podiatrist, and DO is allowable only if the Provider bills the part B carrier for the PC; otherwise, PC may not be claimed separately from the Medical Visit	Applicable CPT Code
Clinical Laboratory	Qualified Technician	CPT Lab Codes
Dental	Dentist, Hygienist under supervision	CDT - HCPC - D codes D9450 (case presentation - CHC enhancement)
340B Pharmacy	Pharmacist	NDC submitted via POPS
Vision Care (diagnostic)	Ophthalmologist, Optometrist	Exam, diagnostic tests
Service	*Provider*	*Codes*
Vision Care (dispensing, repair)	Ophthalmologist, Optometrist, Optician	V-codes glasses; fitting/dispensing/repair
Diabetes Self -Management Treatment	MassHealth approved provider	MassHealth identified codes
Medical Nutrition Therapy	MassHealth approved provider	MassHealth identified codes
Tobacco Cessation Services	MassHealth approved provider	MassHealth identified codes
Preventative Services/Risk Factor Reduction	Same as Medical Visit	99402
Immunization Visits	Same as Medical Visit	90471 - 90473
Vaccines not included in the Medical Visit or supplied by DPH	N/A	CPT codes

13.04 Eligible Services to Low Income Patients.

(1) General. Providers may submit claims for Eligible Services to Low Income Patients determined in accordance with the criteria below. Low Income Patients may be determined eligible for Health Safety Net - Primary; Health Safety Net - Secondary; or Health Safety Net - Partial in accordance with 114.6 CMR 13.04(4). In order to be determined a Low Income Patient; an individual must be a Resident of the Commonwealth and document Family Income equal to or less than 400% of the FPL, subject to the following conditions. The following individuals are not eligible for Low Income Patient status:

(a) Individuals enrolled in MassHealth Standard and MassHealth Family Assistance/Direct Coverage programs;
(b) Individuals who have been determined eligible for any MassHealth program including MassHealth Premium Assistance but who have failed to enroll; and
(c) Individuals whose enrollment in MassHealth or Commonwealth Care has been terminated due to failure to pay premiums.

(2) Low Income Patient Determination. An individual must complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 516.000. Applications will be processed by Office of Medicaid MA-21 system.

(a) Determination Notice. The Office of Medicaid will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) Verification of Income.

1. Verification of gross monthly-earned income is mandatory and shall include, but not be limited to, the following:
   a. Two recent pay stubs;
   b. A signed statement from the employer; or
   c. The most recent U.S. tax return.
2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:
   a. A copy of a recent check or pay stub showing gross income from the source;
   b. A statement from the income source, where matching is not available;
   c. The most recent U.S. Tax Return.
3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.
4. The Division's Electronic Free Care Application issued under 114.6 CMR 10.00 may be used for the following special application types until the Division issues a revised Application.
   a. Confidential Services. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application issued under 114.6 CMR 10.00 until the release of the Application for Health Safety Net Confidential Services. If a minor is determined to be a Low Income Patient, the Provider may submit claims for Confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. Providers may submit claims for Eligible Services rendered to these individuals for Confidential Services only.
   b. An individual who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information if he or she seeks medically necessary Eligible Services. An individual seeking these services is not required to report his or her primary address.

c. An individual who is incarcerated may apply for Low Income Patient status for services provided within six months prior to his or her application.

(c) Matching Information. The Office of Medicaid initiates data matches with other agencies and information sources when a MassHealth application is received. These agencies and information sources may include, but are not limited to, the following: the Department of Employment and Training, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans Services, Department of Revenue, Bureau of Special Investigations, and Department of Transitional Assistance; the federal Internal Revenue Service, Social Security Administration, alien Verification Information System; and health insurance carriers.

(3) Grievance Process. An individual may request that the Division conduct a review of a MA-21 determination of Low Income Patient status, or of Provider compliance with the provisions of 114.6 CMR 13.00. The Health Safety Net Office will conduct a review using the following process.

(a) In order to request a review, the individual must send a written complaint to the Office with supporting documentation. To request a review of an MA-21 determination, the individual must send the review request within 30 days from the date the applicant received the official notification of the determination. For all grievances, the Office may request additional information as necessary from the grievant, other state agencies, and/or the Provider. Additional information requested by the Office must be submitted within 30 days.

(b) The Office will issue a written decision and explanation of the reasons for its decision to the grievant and other relevant parties within 30 days of the receipt of all necessary information.

(4) Low Income Patient Eligibility Categories.

(a) There are three categories of Low Income Patient eligibility for Health Safety Net services:

1. Health Safety Net - Primary. A Low Income Patient is eligible for Health Safety Net - Primary if he or she is uninsured and documents Family Income between 0 and 200% of the FPL.

a. Individuals eligible for enrollment in MassHealth Basic, MassHealth Essential, and Commonwealth Care are not eligible for Health Safety Net -Primary except as provided in 114.6 CMR 13.04 (5) (a), (b) and (c).

b. Students subject to the Qualifying Student Health Plan requirements of M.G.L. c. 15, § 18 are not eligible for Health Safety Net - Primary.

2. Health Safety Net - Secondary. A Low Income Patient is eligible for Health Safety Net - Secondary if he or she has other primary health insurance and documents Family Income between 0 and 200% of the FPL.

a. Individuals enrolled in Commonwealth Care are not eligible for Health Safety Net - Secondary except for dental services not otherwise covered by Commonwealth Care after the date that coverage begins.

b. Individuals enrolled in MassHealth Standard, CommonHealth, MassHealth Essential, MassHealth Basic, or Family Assistance/Direct Coverage are not eligible for Health Safety Net - Secondary.
c. Students enrolled in a Qualifying Student Health Plan are eligible for Health Safety Net - Secondary.

3. Health Safety Net - Partial. A Low Income Patient is eligible for Health Safety Net - Partial if he or she documents Family Income between 201% to 400% of the FPL. The individual is responsible for a deductible under 114.6 CMR 13.06.

(b) Other Requirements

1. Affordable Insurance. Effective October 1, 2008, an individual with income less than or equal to 400% of the FPL, and for whom insurance is deemed affordable as defined in 956 CMR 6.00, is not eligible for Health Safety Net - Primary. If such an individual's employer offers employer-sponsored insurance, he or she is not eligible for Health Safety Net-Primary except during the employer's waiting period before the employer-sponsored insurance becomes effective.
2. Providers may submit claims for individuals whose MassHealth eligibility status is pending due to a disability determination. If the individual is determined eligible for MassHealth, the provider must void Health Safety Net claims for the individual and submit claims for services to MassHealth.

(5) Eligibility Period.

(a) Except for individuals eligible for MassHealth Essential, MassHealth Basic, and Commonwealth Care, Providers may submit claims for individuals determined to be Low Income Patients on or after October 1, 2007, for Reimbursable Services, except pharmacy services, for the period beginning six months prior to the date that Low Income Patient status begins. Providers may submit claims for pharmacy services provided to a Low Income Patient effective on the eligibility start date.
(b) For Low Income Patients eligible for MassHealth Essential and MassHealth Basic who are required to enroll in a Managed Care Organization plan in order to receive MassHealth coverage, Providers may submit claims for Reimbursable Services for the period beginning ten days prior to the date of application, if all required verifications have been received within 60 days of a request for information or beginning ten days prior to the date of determination if all required verifications are submitted later than 60 days from the date of application, and ending on the earlier of 90 days following the date of application or the date of enrollment in MassHealth Basic or MassHealth Essential.
(c) Low Income Patients eligible for Commonwealth Care.

1. Providers may submit claims for Reimbursable Services for the period beginning on the patient's MassHealth eligibility start date and ending on the earlier of 100 days after the patient's MassHealth eligibility start date or the coverage effective date of the patient's Commonwealth Care plan.

2. If a Low Income Patient determined eligible for Commonwealth Care enrolls in Commonwealth Care plan, Providers may submit claims for services provided between the date of enrollment and the coverage effective date.

(d) Low Income Patient status is effective for a maximum of one year from the date of determination, subject to periodic redetermination by MA-21 and verification that the patient's Family Income or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

(6) Low Income Patient Responsibilities.

(a) Cost Sharing Requirements. Low Income Patients are responsible for paying co-payments in accordance with 114.6 CMR 13.04(6)(b) and deductibles in accordance with 114.6 CMR 13.04(6)(c).

(b) Low Income Patient Co-Payment Requirements. Effective March 3, 2008, all Low Income Patients over the age of 18 are responsible for a co-payment of $1 for generic drugs and $3 for single source drugs. There are no co-payments for Reimbursable Services provided to children aged 18 and under. There is an annual maximum of $200 on pharmacy co-payments.

(c) Health Safety Net - Partial Deductibles. For Health Safety Net - Partial patients with Family Income between 201% and 400% of the FPL, there is an annual Deductible equal to 40% of the difference between the applicant's Family Income and 201% of the FPL. The patient is responsible for payment for all services provided up to this Deductible amount. Once the patient has incurred the Deductible, a Provider may submit claims for Eligible Services in excess of the Deductible.

1. There is only one Deductible per Family per approval period. The Deductible is not applied to pharmacy services. Co-payments are not considered expenses to be included in the Deductible amount.
2. Deductible Tracking. The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or Family member during the Eligibility Period. Each Family member must be determined a Low Income Patient in order for his or her expenses for Eligible Services to be applied to the Deductible. The Provider must track the patient's Eligible Service expenses until the patient meets the Deductible. If more than one Family member is determined to be a Low Income Patient, or if the patient or Family members receive services from more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.
3. Hospitals. The patient must incur expenses for Eligible Services in excess of the Annual Deductible before the Provider may submit a claim for Eligible Services. Once the patient has incurred the Deductible, the Provider may submit a claim for the remaining balance of Eligible Service expenses. The Hospital may require a deposit and/or a payment plan in accordance with 114.6 CMR 13.08.

4. Community Health Centers and Hospital Licensed Health Centers. Community Health Centers must offer Low Income Patients a sliding fee scale. Hospital Licensed Health Centers may offer a sliding fee scale for outpatient services. A Low Income Patient must incur a percentage of the Health Safety Net payment rate for eligible services based on the sliding fee scale until the patient meets his or her Deductible. The Provider may submit a claim for the remaining balance of each eligible service.

The sliding fee scale appears below:

Income as a Percentage of Federal Poverty Income Guidelines	Percentage of Rate Paid by Patient
201% to 250%	20%
251% to 300%	40%
301% to 350%	60%
351% to 400%	80%

(7) Motor Vehicle Accidents and Other Recoveries. A Provider may submit a claim for a Low Income Patient injured in a motor vehicle accident only if it (1) has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy; (2) has made every effort to obtain the third party payer information from the patient; (3) has retained evidence of such efforts, including documentation of phone calls and letters to the patient; and (4) where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the Provider must report the recovery to the HSN. The recovery will be offset against the claim for Eligible Services.

13.05: Medical Hardship Services

(1) Eligibility.

(a) General. A Massachusetts Resident at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted his or her family's income that he or she is unable to pay for Eligible Services. A determination of Medical Hardship is a one-time determination and not an ongoing eligibility category. An applicant may submit only two Medical Hardship applications within a twelve-month period.

(b) To qualify for Medical Hardship, the applicant's Allowable Medical Expenses exceed a specified percentage of the applicant's gross income as follows:

Income Level	Percentage of Gross Income
0 - 200% FPL	10%
201 - 300% FPL	15%
301 - 400%	20%
401 - 600% FPL	30%
>601% FPL	40%

(2) Eligibility Determination. An applicant for Medical Hardship must complete a Medical Hardship application and provide required documentation of income and medical expenses. The Health Safety Net Office will process applications for Medical Hardship and verify information contained in the application. Providers must assist the applicant to complete the Medical Hardship application and assemble the required documentation. The Health Safety Net Office will approve an application for Medical Hardship if the applicant's Allowable Medical Expenses exceed the percentage of Family Income listed above. If the applicant reports income less than 400% of the FPL, the applicant must submit an application, with all required documentation, for Low Income Patient determination in accordance with 114.6 CMR 13.04(2). The Health Safety Net Office will not approve Medical Hardship applications for individuals reporting income less than 400% of the FPL unless the applicant has submitted an application for Low Income Patient determination. The Division will not make a determination on Medical Hardship applications for individuals reporting income less than 400% of the FPL until the patient's Low Income status has been determined.

(3) Allowable Medical Expenses. The Division will determine the applicant's Allowable Medical Expenses based on review of the submitted documentation. Allowable Medical Expenses may include only Family medical bills from any health care Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Allowable Medical Expenses include paid and unpaid bills for which the patient is responsible up to twelve months prior to the date of the Medical Hardship application. Allowable Medical Expenses do not include bills for services incurred while the applicant was a Low Income Patient. Bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application.

(4) Applicant Contribution. The applicant's required contribution is the specified percentage of Family Income in 114.6 CMR 13.05(2). There is one Medical Hardship contribution per Family per Medical Hardship determination. The applicant will remain responsible for Allowable Medical Expenses equal to the required contribution, including bills from health care providers other than Massachusetts Hospitals and Community Health Centers. If the applicant is determined a Low Income Patient, the applicant's required contribution will be deferred until the applicant's Low Income Patient status is ended. If the Health Safety Net Office approves two Medical Hardship applications during a twelve-month period, it will prorate the required contribution amounts.

(5) Notification of Determination. The Health Safety Net Office will notify applicants of the determination. The notice will explain that the person is eligible for Medical Hardship; include the dates for which allowable Medical Expenses may be included; include the amount of the applicant's Medical Hardship contribution; list the services that do not qualify as Eligible Services; include the name and number of a contact person for more information. The Office will also notify Providers with bills included in the applicant's Allowable Medical Expenses of the determination and will allocate the applicant's Contribution to each Health Safety Net Provider based on the dates of services and gross charges of services provided to the applicant's family.

(6) Claims. Providers may submit claims for Medical Hardship Services upon notification of an approved Medical Hardship application. The Provider may submit a claim for any balance for Eligible Medical Expenses above the patient's Medical Hardship contribution, noting the Applicant's Medical Hardship contribution on the

claim. All Medical Hardship claims must be submitted using the 837 formats. The Provider may bill the Applicant for the Medical Hardship contribution in accordance with the Health Safety Net Office notice of determination.

13.06: Allowable Bad Debt

(1) General Requirements. Hospitals may submit claims for Emergency Bad Debt as defined in 114.6 CMR 13.06(2). Community Health Centers may submit claims for Urgent Bad Debt as defined in 114.6 CMR 13.06(3). Providers may not submit a claim for a deductible or coinsurance portion of a claim for which an insured patient or Low Income Patient is responsible.

(a) Required Collection Action. Providers may submit claims for Bad Debt only after required collection action, including the following:

1. Collecting Patient Information.

a. Inpatient Services. A Hospital shall identify the department responsible for obtaining the information from the patient, and make reasonable efforts to obtain the financial information necessary to determine responsibility for payment of the Hospital bill from the patient or Guarantor. If the patient or Guarantor is unable to provide the information needed, and the patient consents, a Hospital shall make reasonable efforts to contact the relatives, friends and Guarantor and the patient for additional information while the patient is in the Hospital. If a Hospital has not obtained sufficient patient financial information to assess the ability of the patient or the Guarantor to pay for services prior to the date of discharge, the Hospital shall make reasonable efforts to obtain the necessary information at the time of the patient's discharge.

b. Emergency Room, Outpatient Services and Community Health Center Services. A Provider shall make reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or Guarantor.

2. Verification of Patient-Supplied Information.

a. Inpatient. A Hospital shall make reasonable efforts to verify the patient-supplied information prior to the patient discharge. The verification may occur at any time during the provision of services, at the time of the patient discharge or during the collection process.

b. Hospital Outpatient and Community Health Centers. A Provider shall make reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process.

3. Reasonable Collection Efforts.

a. A Provider must make the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.

b. The minimum requirements before writing off an account to the Health Safety Net include:

i. An initial bill to the party responsible for the patient's personal financial obligations

ii. Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation

iii. Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable"

iv. Sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"

v. Documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, the Health Safety Net Office may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a Provider has made a reasonable effort to meet the standard.

c. If, after reasonable attempts to collect a bill, the debt for Emergency Care for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Health Safety Net Office.

d. The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

(b) Reporting Requirements.

1. Claims submission. Hospitals must submit a claim for each inpatient Bad Debt. Community Health Centers must submit a claim for each Urgent Bad Debt.

2. Additional Information. Providers must submit the following information for Community Health Center and Hospital inpatient services in a form specified by the Division. For outpatient services, Hospitals must submit this information within 30 days of a request by the Health Safety Net Office.

Patient Identifiers:

Name
Address
Phone#
DOB
SSN#
TCN
Med Record#

Mass Health# (RID and/or RHN)
Date of Service
Total Charge for Services
Net Charge submitted to Health Safety Net
Evidence of Reasonable Collection Efforts:
Date of Initial Bill
Date of Second Bill
Date of Third Bill
Date of Fourth Bill
Date of Returned Mail
Date of Certified Letter for accounts over $1,000
Date of Initial Phone Contact
Date of Follow up Phone Contact
Dates of Other Efforts (other phone calls, letters to patient, attorney or referral to collection agency)
Date Account was submitted to Health Safety Net Office

3. The Health Safety Net Office may deny payment for any claim for which required documentation is not submitted. If the Health Safety Net Office notifies a Provider that a claim has been denied due to insufficient documentation, the Provider must submit the required documentation within 30 days of the date of the notice that the claim was denied.

(2) Hospital Emergency Bad Debt Claims.

(a) A Hospital may submit a claim for Emergency Bad Debt if:

1. The services were provided to

a. An uninsured individual who is not a Low Income Patient and the Provider has verified through the REVS system that the individual has not submitted an application for MassHealth; or

b. An uninsured individual whom the Hospital assists in completing a MassHealth application and is determined to be a Low Income Patient;

2. The services provided were Emergency or Urgent Care Services;

3. The Hospital can document that it has undertaken the required Collection Action as defined in 114.6 CMR 13.06(1)(a) for the account; and

4. The bill remains unpaid after a period of 120 days.

(3) Community Health Center Bad Debt.

(a) Community Health Centers may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

1. The services were provided to

a. An uninsured individual who is not a Low Income Patient. The Provider may not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The Provider may not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

b. An uninsured individual whom the Provider assists in completing a MassHealth application and is determined to be a Low Income Patient;

2. The Provider provided Urgent Services as defined in 114.6 CMR 13.02 to the patient. A Provider may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.
3. The responsible physician determined that the patient required Urgent Services. A Provider may submit a claim for Urgent Services, but not for other services provided to patients determined not to require Urgent Services.
4. The Provider undertook the required Collection Action as defined in 114.6 CMR 13.06(1)(a) and submitted the information required in 114.6 CMR 13.06(1)(b) for the account;
5. The bill remains unpaid after a period of 120 days.

(4) DOR Intercept. The Health Safety Net Office will initiate a match with the Department of Revenue for individuals for whom a Provider has submitted a claim for Bad Debt services. The Health Safety Net Office may request that the Department intercept payments to the individual up to an amount equal to the amount paid to the Provider for the Services.

13.07 Reporting Requirements

(1) General. Each Provider shall file or make available information that the Health Safety Net Office deems necessary to verify that a service for which a Provider submits a claim is an Eligible Service.

(a) The Health Safety Net Office may revise the data specifications, the data collection scheduled, or other administrative requirements from time to time by administrative bulletin.
(b) Providers must maintain records sufficient to document compliance with all screening and documentation requirements of 114.6 CMR 13.00. Providers must maintain records documenting claims for Eligible Services to Low Income Patients, Emergency Bad Debt services, and Medical Hardship services.
(c) The Health Safety Net Office may deny payment for Eligible Services to any Provider that fails to comply with the reporting requirements of 114.6 CMR 13.00 or 114.6 CMR 14.00 until such Provider complies with the requirements. The Health Safety Net Office will notify such Provider of its intention to withhold payment.

(2) Claims Submission Deadlines. For all services provided by Hospitals on or after October 1, 2007, and for all services provided by Community Health Centers on or after October 1, 2008, the Health Safety Net Office will pay only for claims that are submitted within the timeframes listed below:

(a) Unless otherwise specified below, claims must be submitted to the Health Safety Net Office within 90 days from the date of service or the date of the primary insurer's explanation of benefits. If a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.
(b) If the Health Safety Net Office is the primary payer, and Low Income Patient status is determined after services are provided, claims must be submitted within 90 days of Low Income Patient determination

(c) Claims for Emergency or Urgent Bad Debt may be written off by the provider no earlier than 120 days after services are provided. Such claims must be submitted within 90 days after the date on which the claim is written off as uncollectible.
(d) Medical Hardship claims must be submitted within 30 days after eligibility is determined.
(e) Pharmacy claims must be submitted to POPS by the later of 90 days after services are provided or 90 days after the date of the primary insurer's Explanation of Benefits.
(f) Denied claims being resubmitted for payment must be submitted within 90 days of the original denial.

(3) Other Hospital Claim Requirements.

(a) Each Hospital claim for Eligible Services must contain a site-specific Identification Number as assigned by the Health Safety Net Office. The Health Safety Net Office will assign individual Identification Numbers to each Hospital, Hospital Licensed Health Centers, satellite clinics, and other off-campus locations that provide Eligible Services.
(b) The Health Safety Net Office may require Hospitals to submit interim data on revenues and costs to monitor compliance with federal Upper Limit and Safety Net Care payment limits. Such data may include, but not be limited to, Gross and Net Patient Service Revenue for Medicaid non-managed care, Medicaid managed care, and all payers combined; and total patient service expenses for all payers combined.

(4) Other Community Health Centers Claim Requirements.

(a) Each Community Health Center must submit claims for Eligible Services to the Health Safety Net Office according to the requirements of 114.6 CMR 13.00 and 114.6 CMR 14.00 and the data specification requirements of the Office.
(c) Each Community Health Center must, upon request, provide the Health Safety Net Office with patient account records and related reports as set forth in 114.6 CMR 13.03(1) (b).

(5) Audits. The Health Safety Net Office or its agent may audit claims for Eligible Services and may adjust claims that are not in compliance with the provisions of 114.6 CMR 13.00.

(a) The Health Safety Net Office may adjust claims for services covered by MassHealth, another program of public assistance, or other health insurance plan in which the patient is enrolled.
(b) The Health Safety Net Office may adjust claims for services that do not meet the criteria for Eligible Services including Services to Low Income Patients, Bad Debt services, or Medical Hardship services.
(c) The Health Safety Net Office may adjust claims for which the Provider cannot provide documentation required by 114.6 CMR 13.00 or 114.6 CMR 14.00.
(d) The Health Safety Net Office may adjust payments using a methodology to appropriately extrapolate the audit results of a representative sample of accounts.
(e) Processing of Audit Adjustments.

1. Notification. After audit, the Health Safety Net Office shall notify the Provider of its proposed audit adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments.

2. Objection Process.

a. A Provider may file a written objection to a proposed audit adjustment within 15 business days of the mailing of the notification letter.

b. The written objection must, at a minimum, contain:

i. Each adjustment to which the Provider is objecting,

ii. The Fiscal Year for each disputed adjustment,

iii. The specific reason for each objection, and

iv. All documentation which supports the Provider's position.

c. Upon review of the Provider's objections, the Health Safety Net Office shall notify the Provider of its determination in writing. If the Health Safety Net Office disagrees with the Provider's objections, in whole or in part, the Health Safety Net Office shall provide the Provider with an explanation of its reasoning.

d. The Provider may request a conference on objections after receiving the Health Safety Net Office's explanation of reasons. The Health Safety Net Office will schedule such conference on objections if it determines that further articulation of the Provider's position would promote resolution of the disputed adjustments.

13.08: Other Requirements

(1) Provider Responsibilities.

(a) A Provider shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

(b) A Provider or agent thereof shall not seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to 114.6 CMR 13.03 without the express approval of the Provider's Board of Trustees. All approvals by the Board must be made on an individual case basis.

(c) Credit and Collection Policies.

1. Filing Requirements. Each Provider must file a copy of its Credit and Collection Policy with the Health Safety Net Office in accordance with the following schedule. The Credit and Collection Policy must conform to the requirements of the regulation.

a. A new Provider must file a copy of its Policy prior to Health Safety Net Office approval to submit claims for payments for Eligible Services;

b. Within 90 days of adoption of amendments to this regulation that would require a change in the Credit and Collection Policy;
c. When a Provider changes its Credit and Collection Policy; or
d. When two Providers merge and request to be paid as a single merged entity.

2. Content Requirements. A Provider's Credit and Collection Policy must contain:

a. Standard collection policies and procedures; or specify the location where the detailed policy is available for Health Safety Net Office review upon request;
b. Policies and procedures for collecting financial information from patients;
c. Emergency Care Classification. A Hospital must provide a detailed policy on its practices for classifying persons presenting themselves for unscheduled treatment, the urgency of treatment associated with each identified classification, the location(s) at which patients might present themselves, and any other relevant and necessary instructions to Hospital personnel that would see these patients. The policy must include the classifications which qualify as Emergency Services and other services including "elective" or "scheduled" services;
d. The policy on deposits and payment plans for qualified patients as described in 114.6 CMR 13.08;
e. Copies of billing invoices, award or denial letters, and any other documents used to inform patients of the availability of assistance; and
f. Description of any program by which the Hospital offers discounts from charges for the uninsured.

(d) Notices.

1. A Provider must provide individual notice of the availability of financial assistance programs, including Medical Hardship, to a patient expected to incur charges, exclusive of personal convenience items or services, which may not be paid in full by third party coverage.
2. A Provider or its designee must include a notice about Eligible Services to Low Income Patients and programs of public assistance in its initial bill.
3. A Provider must include a brief notice about Eligible Services to Low Income Patients in all written Collection Actions. The following language is suggested, but not required, to meet the notice requirements of this section: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."
4. A Provider must notify the patient that the Provider offers a payment plan as described in 114.6 CMR 13.08, if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(e) Signs. Providers must post signs, in the inpatient, clinic, and emergency admissions/registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of

financial assistance programs and the Provider location at which to apply for such programs. Signs must be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices must be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the Provider's service area. Signs must notify patients of the availability of financial assistance and of other programs of public assistance. The following language is suggested, but not required:
1. "Are you unable to pay your hospital bills? Please contact a counselor to assist you with various alternatives." or
2. "Financial assistance is available through this institution. Please contact _____."

(f) Deposits and Payment Plans.

1. A Provider may not require pre-admission and/or pretreatment deposits from individuals that require Emergency Services or that are determined to be Low Income Patients.
2. A Provider may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the Deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 13.08.
3. A Provider may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 13.08.
4. An individual with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than $25. A patient that has a balance of more than $1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

(2) Patient Rights and Responsibilities.

(a) Providers must advise patients of the right to:

1. Apply for MassHealth, Commonwealth Care, Low Income Patient determination, and Medical Hardship; and
2. A payment plan, as described in 114.6 CMR 13.08, if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(b) A Patient that receives Eligible Services must:

1. Provide all required documentation;
2. Inform MassHealth or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status; and
3. Track the patient Deductible and provide documentation to the Provider that the Deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.

(3) Populations exempt from Collection Action

(a) A Provider shall not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, except that the Provider may bill patients for any required co-payments and deductibles. The Provider may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider shall cease its collection activities.

(b) Participants in the Children's Medical Security Plan whose Family Income is equal to or less than 400% of the FPL are also exempt from Collection Action. The Provider may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Provider shall cease all collection activities.

(c) Low Income Patients are exempt from Collection Action for any Eligible services rendered by a Provider receiving payments from the Health Safety Net Office for services received during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. Providers may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

(d) Low Income Patients with Income between 201 to 400% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 114.6 CMR 13.04. Providers may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

(e) Providers may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed to be responsible. Providers must obtain the patient's written consent to be billed for the service.

(f) A Provider may not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.

(4) Severability. The provisions of 114.6 CMR 13.00 are severable. If any provision or the application of any provision to any Hospital, Community Health Center, surcharge payer or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.60 CMR 13.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(5) Administrative Information Bulletins. The Health Safety Net Office may issue administrative information bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 13.00 and specify information and documentation necessary to implement 114.6 CMR 13.00.

114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
MEDICAL SECURITY BUREAU

114.6 CMR 13.00: HEALTH SAFETY NET ELIGIBLE SERVICES

REGULATORY AUTHORITY

114.6 CMR 13.00 M.G.L. c. 118G.